STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named home plus conducted on 08/19/24.	S 000		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of 1 resident which was included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 described the services he received based on his "Functional Capacity Screen" (FCS). Findings included:	S5105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 1 - Record review for R1 revealed an admission date of 02/07/22 with a diagnosis of traumatic brain injury. The 01/10/24 "FCS" identified R1 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was identified at risk for falls, wandering, and inappropriate behavior. The 01/11/24 The "NSA" failed to describe the services R1 received for cognition, falls, wandering, and inappropriate behavior. On 08/19/24 at approximately 10:34 AM Licensed Nurse B confirmed R1's "NSA" failed to describe the services he received based on his "FCS." The operator failed to ensure the "NSA" for R1 described the services he received based on his "FCS."	S5105		
S5126 SS=F	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(h) The facility reported a census of 1 resident which was included in the sample. Based on interview and record review the operator failed to obtain the	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5126	Continued From page 2	S5126		

signatures of each individual involved in the development of the "Negotiated Service Agreement" (NSA) for Resident (R) 1.

Findings included:

- Record review for R1 revealed an admission date of 02/07/22 with a diagnosis of traumatic brain injury.

The 01/10/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with management of medications and treatments; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was identified at risk for falls, impaired vision, impaired hearing, impaired decision-making, wandering, and inappropriate behavior.

The 01/11/24 "NSA" identified facility staff would provide management of medications and treatments; he wore glasses for impaired vision and hearing aids for impaired hearing; and had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe the services R1 received for cognition, falls, wandering, and inappropriate behavior.

R1's "NSA" lacked a signature by his DPOA.

On 08/19/24 at 11:12 AM Licensed Nurse B confirmed R1's record lacked evidence of documentation of each individual's signature involved in the development of the "NSA."

The operator failed to obtain signatures of each individual involved in the development of the "NSA" for R1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 3	S5230		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of one resident which was included in the sample. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for Resident (R) 1. Findings included: - Record review for R1 revealed an admission date of 02/07/22 with a diagnosis of traumatic brain injury. R1's record lacked evidence of documentation a TB symptom screening was completed annually.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 4 On 08/09/24 at approximately 10:34 AM Licensed Nurse B confirmed R1's lacked evidence of documentation a TB symptom screening was completed annually. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each resident shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5326 SS=F	26-42-205 (l) (1) Medication Regimen Review Contents (l) (1) The medication regimen review shall identify any potential or current medication-related problems, including the following: (A) Lack of clinical indication for use of medication; (B) the use of a subtherapeutic dose of any medication; (C) failure of the resident to receive an ordered medication; (D) medications administered in excessive dosage, including duplicate therapy; (E) medications administered in excessive duration; (F) adverse medication reactions; (G) medication interactions; and (H) lack of adequate monitoring. This REQUIREMENT is not met as evidenced	S5326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5326	Continued From page 5 by: KAR 26-42-205(l)(1) The facility reported a census of 1 resident which was included in the sample. Based on interview and record review the operator failed to ensure designated staff ensured the medication regimen review for Resident (R) 1 identified all potential or current medication related problems. Findings included: - Record review for R1 revealed an admission date of 02/07/22 with a diagnosis of traumatic brain injury. The 01/10/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with management of medications. The 01/11/24 The "Negotiated Service Agreement" (NSA) identified facility staff provide medication administration under the supervision of a licensed nurse. Review of R1's most recent "Medication Regimen Review" revealed a signature by Licensed Nurse B. The "Medication Regimen Review" lacked evidence of documentation any potential or current medication-related problems were identified. On 08/19/24 at approximately 10:34 AM Licensed Nurse B confirmed R1's "Medication Regimen Review" failed to identify any potential or current medication-related problems. The operator failed to ensure the "NSA" for R1 described the services he received based on his "FCS."	S5326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008006	A. BUILDING: _____ B. WING _____	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HULLS HAVEN	401 PARKWOOD ROSE HILL, KS 67133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE